

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2805 -62-023538
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2805

VS 300
Rev. 4/59

1
2 9328
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4 2
5 1
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7 1
8 1
9 9330X
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12 90-3
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 18th & Troost		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson c. CITY OR TOWN Kansas City d. STREET ADDRESS (If outside, give location) 2109 Troost	
3. NAME OF DECEASED (Type or print) Garrett Williams		4. DATE OF DEATH Month May Day 16 Year 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-5-1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker		10b. KIND OF BUSINESS OR INDUSTRY Laundry	11. BIRTHPLACE (City and state or country) Atlanta Georgia
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. 2		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Dorothy Williams		17. INFORMANT Address 2109 Troost	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage DUE TO (b) Acute Gastritis DUE TO (c) Unmasticated Stomach contents.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour [REDACTED] a.m. [REDACTED] p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION [REDACTED]
21. I attended the deceased from _____, to _____, and last saw her alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Deputy Coroner	
22b. ADDRESS 1618 Lydia Ave		22c. DATE SIGNED 5/17/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-1-1962	23c. NAME OF CEMETERY OR CREMATORY National	23d. LOCATION (City, town, or county) Ft Leavenworth
24. FUNERAL DIRECTOR Marlowe and Williams		25. DATE RECD. BY LOCAL REG. 5-24-62	26. REGISTRAR'S SIGNATURE Ruth H Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eddie Middleton

Licensed Embalmer No. 5046

P. O. Address Z. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.